Medicare Learning Network
MLN Matters
CMS CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

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Related CR Transmittal #: 407
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Hospital Billing for Repetitive Services

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Hospitals billing Medicare fiscal intermediaries (FIs)

Provider Action Needed

Hospitals should note that this article provides information contained in Change Request (CR) 3633 that is related to hospital billing for repetitive services. The Centers for Medicare & Medicaid Services (CMS) has decided to re-evaluate the policy of repetitive billing in order to reduce the burden on hospitals and still maintain the ability to achieve accurate data for Ambulatory Patient Classification (APC) recalibration.

CMS is also clarifying that the list of repetitive services is a complete list in the *Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 (General Billing Requirements), Section 50.2.2 (Frequency of Billing for Outpatient Services to FIs)*. See the *Additional Information* section below. Finally, CMS is also modifying billing for chemotherapy services.

Background

CMS) issued CR3382 on August 3, 2004, (Transmittal 270 – Update to Frequency of Billing), and it was to become effective January 1, 2005. CR 3382 updated instructions for hospitals billing repetitive services to allow CMS to accept more singleton claims (claims with only one significant procedure) for APC rate-setting.

However, in November, 2004, CMS was notified by concerned hospitals of possible difficulties that might arise from such changes. To be responsive to these hospital concerns, CMS has re-evaluated the repetitive services billing policy in order to reduce the burden on hospitals and still maintain the ability to achieve accurate data for APC recalibration:

- Beginning January 1, 2005, repetitive service bills may include services paid under the clinical laboratory fee schedule. However, to allow for APC recalibration, repetitive bills may no longer include other non-repetitive services (even if both the non-repetitive service and the repetitive service are paid under the outpatient prospective payment system (OPPS).

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- If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service is to be billed on a separate OPPS claim containing the individual service and all packaged and/or related services.

Note: Providers are strongly encouraged to separate repetitive services from non-repetitive services effective January 1, 2005. However, to allow sufficient time for providers to adjust their operations, CMS has delayed editing that would enforce providers to separate repetitive services from non-repetitive services. Providers will be given advance notice of the effective date for such editing per a future MLN Matters article.

EXAMPLE

A patient receives a radiation therapy treatment (a repetitive service [revenue code 0333] on the repetitive service list) and on the same day the patient receives the following:

- An outpatient consultation;
- A CT scan; and
- Clinical laboratory services.

The hospital will report:

- The radiation therapy on the monthly claim (with the other radiation therapy services);
- The visit for the outpatient consultation and CT scan on a separate claim (from that submitted for the radiation therapy); and
- The clinical laboratory services on either claim.

Similarly, if a chemotherapy drug is administered on the same day a repetitive service is rendered, then the chemotherapy drug, its administration, and its related supplies are reported on a separate claim from the monthly repetitive services claim.

Note: Chemotherapy administration is no longer a repetitive service as defined in the *Medicare Claims Processing Manual (Pub. 100-04, Chapter 1, Section 50.2.2)*. However, chemotherapy is commonly administered during multiple encounters in a month. Where there are multiple encounters for chemotherapy or other non-repetitive services in a month, they may all be reported on the same claim, or they may be billed separately.

Note: CMS does not believe Brachytherapy meets the criteria for repetitive billing. Consequently, CMS prefers that hospitals bill Brachytherapy in revenue code 0342, rather than revenue code 0333 (which is specific to repetitive services).

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Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

To briefly recap:

- FIs will allow claims not paid under the OPPS (laboratory services) to be included on an OPPS claim.
- FIs will not allow claims with repetitive services to be billed on the same claim with non-repetitive services furnished on the same date of service, even if the repetitive and non-repetitive services are both paid under the OPPS. Note: Providers are strongly encouraged to separate repetitive services from non-repetitive services effective January 1, 2005. However, to allow sufficient time for providers to adjust their operations, CMS has delayed editing that would enforce providers to separate repetitive services from non-repetitive services. Providers will be given advance notice of the effective date for such editing per a future MLN Matters article.
- FIs will accept claims with multiple encounters of non-repetitive services, throughout multiple days in a month, to be included on a single claim or separate claims.
- The list of repetitive claims is all-inclusive as shown in the following paragraph and table.

Definition of Repetitive Part B Services

The following was taken from the *Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 (General Billing Requirements), Section 50.2.2 (Frequency of Billing for Outpatient Services to FIs)*:

Repetitive Part B services are defined as services billed under the following (and only the following) revenue codes:

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Radiation Therapy	0333
Respiratory Therapy	0410 – 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech Pathology	0440 – 0449
Home Health Visits	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Psychological Services	0900, 0901, 0911 - 0919 (in a psychiatric facility)

Note: This does not apply to Home Health Agency (HHA) Services. See the *Medicare Claims Processing Manual (Pub. 100-04, Chapter 10)* for HHA requirements.

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For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction includes the revised sections 50.2.1 and 50.2.2 of Chapter 1 of the *Medicare Claims Processing Manual*. The instruction, CR3633, may be viewed by going to http://www.cms.hhs.gov/transmittals/Downloads/R407CP.pdf on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.

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